RIFANS SUPPLIER REGISTRATION PACKAGE

W-9 Substitute/E-Verify

Business Designation:

Please check only ONE:

□ Individual □ Medical Services Corporation □ Government/Nonprofit

□ Partnership □ Corporation □ Trust/Estate □ Legal Svs. Corporation

Taxpayer Identification Number (T.I.N.)

Social Security Number (SSN)	Employer ID Number (EIN)

Name: _____

Address: _____ Remittance: _____

City, State and Zip Code: _____

Certification: Under penalties of perjury, I certify that:

(1.) As it relates to my T.I.N the number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), **and**

(2.) As it relates to my T.I.N I am not subject to backup withholding either because: (A) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interests or dividends, or (B) the IRS has notified me that I am no longer subject to backup withholding.

(3.) As it relates to the "E-Verify" program, I/We certify that I/We have registered to utilize the e-verify program (www.dhs.gov/E-Verify)to ensure compliance with federal and state law. I understand and agree that I am required to continue to utilize the services of the E-Verify program for as long as I continue to do business with the State of Rhode Island. I further understand that my failure to continue to utilize the services of the E-Verify program will adversely affect my ability to continue to do business with the State of Rhode Island and my ability to do business with the State of Rhode Island in the future.

Certification Instructions – You must cross out item (2) above if you have been notified by the IRS that you are subject to backup withholding because of under-reporting interest or dividends on your tax return. However, if after being notified by the IRS that you were subject to backup withholding you received another notification from IRS that you are no longer subject to backup withholding, do not cross out item (2).

I hereby swear or affirm that the information given on this Supplier Information Questionnaire is true and correct to the best of my knowledge and belief.

If there is a change in status that affects the information provided in this Questionnaire, the undersigned agrees to provide notice of change to the State of Rhode Island Division of Purchases, Department of Administration within ten (10) days after said change.

FIRM: _____

BY: _____ **Date:** _____

(Signature)

NAME: _____

(Please Print)

TITLE: _____

MAIL TO: VENDOR FILE COORDINATOR, ONE CAPITOL HILL, PROVIDENCE, RI 02908